

**House File 685 - Introduced**

HOUSE FILE 685

BY COMMITTEE ON WAYS AND MEANS

(SUCCESSOR TO HF 525)

(SUCCESSOR TO HSB 177)

**A BILL FOR**

1 An Act relating to the Medicaid program including third-party  
2 recovery and taxation of Medicaid managed care organization  
3 premiums.

4 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

DIVISION I

MEDICAID PROGRAM THIRD-PARTY RECOVERY

1  
2  
3 Section 1. Section 249A.37, Code 2023, is amended by  
4 striking the section and inserting in lieu thereof the  
5 following:

6 **249A.37 Duties of third parties.**

7 1. For the purposes of this section, "*Medicaid payor*",  
8 "*recipient*", "*third party*", and "*third-party benefits*" mean the  
9 same as defined in section 249A.54.

10 2. The third-party obligations specified under this section  
11 are a condition of doing business in the state. A third party  
12 that fails to comply with these obligations shall not be  
13 eligible to do business in the state.

14 3. A third party that is a carrier, as defined in section  
15 514C.13, shall enter into a health insurance data match program  
16 with the department for the sole purpose of comparing the  
17 names of the carrier's insureds with the names of recipients  
18 as required by section 505.25.

19 4. A third party shall do all of the following:

20 a. Cooperate with the Medicaid payor in identifying  
21 recipients for whom third-party benefits are available  
22 including but not limited to providing information to determine  
23 the period of potential third-party coverage, the nature of  
24 the coverage, and the name, address, and identifying number  
25 of the coverage. In cooperating with the Medicaid payor, the  
26 third party shall provide information upon the request of the  
27 Medicaid payor in a manner prescribed by the Medicaid payor or  
28 as agreed upon by the department and the third party.

29 b. (1) Accept the Medicaid payor's rights of recovery  
30 and assignment to the Medicaid payor as a subrogee, assignee,  
31 or lienholder under section 249A.54 for payments which the  
32 Medicaid payor has made under the Medicaid state plan or under  
33 a waiver of such state plan.

34 (2) In the case of a third party other than the original  
35 Medicare fee-for-service program under parts A and B of Tit.

1 XVIII of the federal Social Security Act, a Medicare advantage  
2 plan offered by a Medicare advantage organization under part C  
3 of Tit. XVIII of the federal Social Security Act, a reasonable  
4 cost reimbursement contract under 42 U.S.C. §1395mm, a health  
5 care prepayment plan under 42 U.S.C. §1395l, or a prescription  
6 drug plan offered by a prescription drug plan sponsor under  
7 part D of Tit. XVIII of the federal Social Security Act that  
8 requires prior authorization for an item or service furnished  
9 to an individual eligible to receive medical assistance  
10 under Tit. XIX of the federal Social Security Act, accept  
11 authorization provided by the Medicaid payor that the health  
12 care item or service is covered under the Medicaid state plan  
13 or waiver of such state plan for such individual, as if such  
14 authorization were the prior authorization made by the third  
15 party for such item or service.

16 *c.* If, on or before three years from the date a health care  
17 item or service was provided, the Medicaid payor submits an  
18 inquiry regarding a claim for payment that was submitted to the  
19 third party, respond to that inquiry not later than sixty days  
20 after receiving the inquiry.

21 *d.* Respond to any Medicaid payor's request for payment of a  
22 claim described in paragraph "c" not later than ninety business  
23 days after receipt of written proof of the claim, either by  
24 paying the claim or issuing a written denial to the Medicaid  
25 payor.

26 *e.* Not deny any claim submitted by a Medicaid payor solely  
27 on the basis of the date of submission of the claim, the type  
28 or format of the claim form, a failure to present proper  
29 documentation at the point-of-sale that is the basis of the  
30 claim; or in the case of a third party other than the original  
31 Medicare fee-for-service program under parts A and B of Tit.  
32 XVIII of the federal Social Security Act, a Medicare advantage  
33 plan offered by a Medicare advantage organization under part C  
34 of Tit. XVIII of the federal Social Security Act, a reasonable  
35 cost reimbursement contract under 42 U.S.C. §1395mm, a health

1 care prepayment plan under 42 U.S.C. §1395l, or a prescription  
2 drug plan offered by a prescription drug plan sponsor under  
3 part D of Tit. XVIII of the federal Social Security Act, solely  
4 on the basis of a failure to obtain prior authorization for the  
5 health care item or service for which the claim is submitted if  
6 all of the following conditions are met:

7 (1) The claim is submitted to the third party by the  
8 Medicaid payor no later than three years after the date on  
9 which the health care item or service was furnished.

10 (2) Any action by the Medicaid payor to enforce its rights  
11 under section 249A.54 with respect to such claim is commenced  
12 not later than six years after the Medicaid payor submits the  
13 claim for payment.

14 5. Notwithstanding any provision of law to the contrary,  
15 the time limitations, requirements, and allowances specified  
16 in this section shall apply to third-party obligations under  
17 this section.

18 6. The department may adopt rules pursuant to chapter 17A  
19 as necessary to administer this section. Rules governing  
20 the exchange of information under this section shall be  
21 consistent with all laws, regulations, and rules relating to  
22 the confidentiality or privacy of personal information or  
23 medical records, including but not limited to the federal  
24 Health Insurance Portability and Accountability Act of 1996,  
25 Pub. L. No. 104-191, and regulations promulgated in accordance  
26 with that Act and published in 45 C.F.R. pts. 160 - 164.

27 Sec. 2. Section 249A.54, Code 2023, is amended by striking  
28 the section and inserting in lieu thereof the following:

29 **249A.54 Responsibility for payment on behalf of**  
30 **Medicaid-eligible persons — liability of other parties.**

31 1. It is the intent of the general assembly that a Medicaid  
32 payor be the payor of last resort for medical services  
33 furnished to recipients. All other sources of payment for  
34 medical services are primary relative to medical assistance  
35 provided by the Medicaid payor. If benefits of a third party

1 are discovered or become available after medical assistance has  
2 been provided by the Medicaid payor, it is the intent of the  
3 general assembly that the Medicaid payor be repaid in full and  
4 prior to any other person, program, or entity. The Medicaid  
5 payor shall be repaid in full from and to the extent of any  
6 third-party benefits, regardless of whether a recipient is made  
7 whole or other creditors are paid.

8 2. For the purposes of this section:

9 a. "*Collateral*" means all of the following:

10 (1) Any and all causes of action, suits, claims,  
11 counterclaims, and demands that accrue to the recipient  
12 or to the recipient's agent, related to any covered injury  
13 or illness, or medical services that necessitated that the  
14 Medicaid payor provide medical assistance to the recipient.

15 (2) All judgments, settlements, and settlement agreements  
16 rendered or entered into and related to such causes of action,  
17 suits, claims, counterclaims, demands, or judgments.

18 (3) Proceeds.

19 b. "*Covered injury or illness*" means any sickness, injury,  
20 disease, disability, deformity, abnormality disease, necessary  
21 medical care, pregnancy, or death for which a third party is,  
22 may be, could be, should be, or has been liable, and for which  
23 the Medicaid payor is, or may be, obligated to provide, or has  
24 provided, medical assistance.

25 c. "*Medicaid payor*" means the department or any person,  
26 entity, or organization that is legally responsible by  
27 contract, statute, or agreement to pay claims for medical  
28 assistance including but not limited to managed care  
29 organizations and other entities that contract with the state  
30 to provide medical assistance under chapter 249A.

31 d. "*Medical service*" means medical or medically related  
32 institutional or noninstitutional care, or a medical or  
33 medically related institutional or noninstitutional good, item,  
34 or service covered by Medicaid.

35 e. "*Payment*" as it relates to third-party benefits, means

1 performance of a duty, promise, or obligation, or discharge of  
2 a debt or liability, by the delivery, provision, or transfer of  
3 third-party benefits for medical services. "To pay" means to  
4 make payment.

5 *f.* "Proceeds" means whatever is received upon the sale,  
6 exchange, collection, or other disposition of the collateral  
7 or proceeds from the collateral and includes insurance payable  
8 because of loss or damage to the collateral or proceeds. "Cash  
9 proceeds" include money, checks, and deposit accounts and  
10 similar proceeds. All other proceeds are "noncash proceeds".

11 *g.* "Recipient" means a person who has applied for medical  
12 assistance or who has received medical assistance.

13 *h.* "Recipient's agent" includes a recipient's legal  
14 guardian, legal representative, or any other person acting on  
15 behalf of the recipient.

16 *i.* "Third party" means an individual, entity, or program,  
17 excluding Medicaid, that is or may be liable to pay all or a  
18 part of the expenditures for medical assistance provided by a  
19 Medicaid payor to the recipient. A third party includes but is  
20 not limited to all of the following:

- 21 (1) A third-party administrator.
- 22 (2) A pharmacy benefits manager.
- 23 (3) A health insurer.
- 24 (4) A self-insured plan.
- 25 (5) A group health plan, as defined in section 607(1) of the  
26 federal Employee Retirement Income Security Act of 1974.
- 27 (6) A service benefit plan.
- 28 (7) A managed care organization.
- 29 (8) Liability insurance including self-insurance.
- 30 (9) No-fault insurance.
- 31 (10) Workers' compensation laws or plans.
- 32 (11) Other parties that by law, contract, or agreement  
33 are legally responsible for payment of a claim for medical  
34 services.

35 *j.* "Third-party benefits" mean any benefits that are or may

1 be available to a recipient from a third party and that provide  
2 or pay for medical services. *Third-party benefits* may be  
3 created by law, contract, court award, judgment, settlement,  
4 agreement, or any arrangement between a third party and any  
5 person or entity, recipient, or otherwise. *Third-party*  
6 *benefits* include but are not limited to all of the following:

- 7 (1) Benefits from collateral or proceeds.
- 8 (2) Health insurance benefits.
- 9 (3) Health maintenance organization benefits.
- 10 (4) Benefits from preferred provider arrangements and  
11 prepaid health clinics.
- 12 (5) Benefits from liability insurance, uninsured and  
13 underinsured motorist insurance, or personal injury protection  
14 coverage.
- 15 (6) Medical benefits under workers' compensation.
- 16 (7) Benefits from any obligation under law or equity to  
17 provide medical support.

18 3. Third-party benefits for medical services shall be  
19 primary to medical assistance provided by the Medicaid payor.

20 4. *a.* A Medicaid payor has all of the rights, privileges,  
21 and responsibilities identified under this section. Each  
22 Medicaid payor is a Medicaid payor to the extent of the  
23 medical assistance provided by that Medicaid payor. Therefore,  
24 Medicaid payors may exercise their Medicaid payor's rights  
25 under this section concurrently.

26 *b.* Notwithstanding the provisions of this subsection to the  
27 contrary, if the department determines that a Medicaid payor  
28 has not taken reasonable steps within a reasonable time to  
29 recover third-party benefits, the department may exercise all  
30 of the rights of the Medicaid payor under this section to the  
31 exclusion of the Medicaid payor. If the department determines  
32 the department will exercise such rights, the department shall  
33 give notice to third parties and to the Medicaid payor.

34 5. A Medicaid payor may assign the Medicaid payor's rights  
35 under this section, including but not limited to an assignment

1 to another Medicaid payor, a provider, or a contractor.

2 6. After the Medicaid payor has provided medical assistance  
3 under the Medicaid program, the Medicaid payor shall seek  
4 reimbursement for third-party benefits to the extent of the  
5 Medicaid payor's legal liability and for the full amount of  
6 the third-party benefits, but not in excess of the amount of  
7 medical assistance provided by the Medicaid payor.

8 7. On or before the thirtieth day following discovery by  
9 a recipient of potential third-party benefits, a recipient or  
10 the recipient's agent, as applicable, shall inform the Medicaid  
11 payor of any rights the recipient has to third-party benefits  
12 and of the name and address of any person that is or may be  
13 liable to provide third-party benefits.

14 8. When the Medicaid payor provides or becomes liable for  
15 medical assistance, the Medicaid payor has the following rights  
16 which shall be construed together to provide the greatest  
17 recovery of third-party benefits:

18 a. The Medicaid payor is automatically subrogated to any  
19 rights that a recipient or a recipient's agent or legally  
20 liable relative has to any third-party benefit for the full  
21 amount of medical assistance provided by the Medicaid payor.  
22 Recovery pursuant to these subrogation rights shall not be  
23 reduced, prorated, or applied to only a portion of a judgment,  
24 award, or settlement, but shall provide full recovery to the  
25 Medicaid payor from any and all third-party benefits. Equities  
26 of a recipient or a recipient's agent, creditor, or health care  
27 provider shall not defeat, reduce, or prorate recovery by the  
28 Medicaid payor as to the Medicaid payor's subrogation rights  
29 granted under this paragraph.

30 b. By applying for, accepting, or accepting the benefit  
31 of medical assistance, a recipient or a recipient's agent or  
32 legally liable relative automatically assigns to the Medicaid  
33 payor any right, title, and interest such person has to any  
34 third-party benefit, excluding any Medicare benefit to the  
35 extent required to be excluded by federal law.

1 (1) The assignment granted under this paragraph is absolute  
2 and vests legal and equitable title to any such right in the  
3 Medicaid payor, but not in excess of the amount of medical  
4 assistance provided by the Medicaid payor.

5 (2) The Medicaid payor is a bona fide assignee for value in  
6 the assigned right, title, or interest and takes vested legal  
7 and equitable title free and clear of latent equities in a  
8 third party. Equities of a recipient or a recipient's agent,  
9 creditor, or health care provider shall not defeat or reduce  
10 recovery by the Medicaid payor as to the assignment granted  
11 under this paragraph.

12 c. The Medicaid payor is entitled to and has an automatic  
13 lien upon the collateral for the full amount of medical  
14 assistance provided by the Medicaid payor to or on behalf of  
15 the recipient for medical services furnished as a result of any  
16 covered injury or illness for which a third party is or may be  
17 liable.

18 (1) The lien attaches automatically when a recipient first  
19 receives medical services for which the Medicaid payor may be  
20 obligated to provide medical assistance.

21 (2) The filing of the notice of lien with the clerk of  
22 the district court in the county in which the recipient's  
23 eligibility is established pursuant to this section shall be  
24 notice of the lien to all persons. Notice is effective as of  
25 the date of filing of the notice of lien.

26 (3) If the Medicaid payor has actual knowledge that the  
27 recipient is represented by an attorney, the Medicaid payor  
28 shall provide the attorney with a copy of the notice of lien.  
29 However, this provision of a copy of the notice of lien to  
30 the recipient's attorney does not abrogate the attachment,  
31 perfection, and notice satisfaction requirements specified  
32 under subparagraphs (1) and (2).

33 (4) Only one claim of lien need be filed to provide notice  
34 and shall provide sufficient notice as to any additional  
35 or after-paid amount of medical assistance provided by the

1 Medicaid payor for any specific covered injury or illness.  
2 The Medicaid payor may, in the Medicaid payor's discretion,  
3 file additional, amended, or substitute notices of lien at any  
4 time after the initial filing until the Medicaid payor has  
5 been repaid the full amount of medical assistance provided  
6 by Medicaid or otherwise has released the liable parties and  
7 recipient.

8 (5) A release or satisfaction of any cause of action,  
9 suit, claim, counterclaim, demand, judgment, settlement, or  
10 settlement agreement shall not be effective as against a lien  
11 created under this paragraph, unless the Medicaid payor joins  
12 in the release or satisfaction or executes a release of the  
13 lien. An acceptance of a release or satisfaction of any cause  
14 of action, suit, claim, counterclaim, demand, or judgment and  
15 any settlement of any of the foregoing in the absence of a  
16 release or satisfaction of a lien created under this paragraph  
17 shall prima facie constitute an impairment of the lien, and  
18 the Medicaid payor is entitled to recover damages on account  
19 of such impairment. In an action on account of impairment of a  
20 lien, the Medicaid payor may recover from the person accepting  
21 the release or satisfaction or the person making the settlement  
22 the full amount of medical assistance provided by the Medicaid  
23 payor.

24 (6) The lack of a properly filed claim of lien shall not  
25 affect the Medicaid payor's assignment or subrogation rights  
26 provided in this subsection nor affect the existence of the  
27 lien, but shall only affect the effective date of notice.

28 (7) The lien created by this paragraph is a first lien  
29 and superior to the liens and charges of any provider of a  
30 recipient's medical services. If the lien is recorded, the  
31 lien shall exist for a period of seven years after the date of  
32 recording. If the lien is not recorded, the lien shall exist  
33 for a period of seven years after the date of attachment. If  
34 recorded, the lien may be extended for one additional period  
35 of seven years by rerecording the claim of lien within the

1 ninety-day period preceding the expiration of the lien.

2 9. Except as otherwise provided in this section, the  
3 Medicaid payor shall recover the full amount of all medical  
4 assistance provided by the Medicaid payor on behalf of the  
5 recipient to the full extent of third-party benefits. The  
6 Medicaid payor may collect recovered benefits directly from any  
7 of the following:

8 a. A third party.

9 b. The recipient.

10 c. The provider of a recipient's medical services if  
11 third-party benefits have been recovered by the provider.  
12 Notwithstanding any provision of this section to the contrary,  
13 a provider shall not be required to refund or pay to the  
14 Medicaid payor any amount in excess of the actual third-party  
15 benefits received by the provider from a third party for  
16 medical services provided to the recipient.

17 d. Any person who has received the third-party benefits.

18 10. a. A recipient and the recipient's agent shall  
19 cooperate in the Medicaid payor's recovery of the recipient's  
20 third-party benefits and in establishing paternity and support  
21 of a recipient child born out of wedlock. Such cooperation  
22 shall include but is not limited to all of the following:

23 (1) Appearing at an office designated by the Medicaid payor  
24 to provide relevant information or evidence.

25 (2) Appearing as a witness at a court proceeding or other  
26 legal or administrative proceeding.

27 (3) Providing information or attesting to lack of  
28 information under penalty of perjury.

29 (4) Paying to the Medicaid payor any third-party benefit  
30 received.

31 (5) Taking any additional steps to assist in establishing  
32 paternity or securing third-party benefits, or both.

33 b. Notwithstanding paragraph "a", the Medicaid payor has the  
34 discretion to waive, in writing, the requirement of cooperation  
35 for good cause shown and as required by federal law.

1     *c.* The department may deny or terminate eligibility for  
2 any recipient who refuses to cooperate as required under this  
3 subsection unless the department has waived cooperation as  
4 provided under this subsection.

5     11. On or before the thirtieth day following the initiation  
6 of a formal or informal recovery, other than by filing a  
7 lawsuit, a recipient's attorney shall provide written notice of  
8 the activity or action to the Medicaid payor.

9     12. A recipient is deemed to have authorized the Medicaid  
10 payor to obtain and release medical information and other  
11 records with respect to the recipient's medical services  
12 for the sole purpose of obtaining reimbursement for medical  
13 assistance provided by the Medicaid payor.

14     13. *a.* To enforce the Medicaid payor's rights under  
15 this section, the Medicaid payor may, as a matter of right,  
16 institute, intervene in, or join in any legal or administrative  
17 proceeding in the Medicaid payor's own name, and in any or a  
18 combination of any, of the following capacities:

- 19       (1) Individually.  
20       (2) As a subrogee of the recipient.  
21       (3) As an assignee of the recipient.  
22       (4) As a lienholder of the collateral.

23     *b.* An action by the Medicaid payor to recover damages  
24 in an action in tort under this subsection, which action is  
25 derivative of the rights of the recipient, shall not constitute  
26 a waiver of sovereign immunity.

27     *c.* A Medicaid payor, other than the department, shall obtain  
28 the written consent of the department before the Medicaid payor  
29 files a derivative legal action on behalf of a recipient.

30     *d.* When a Medicaid payor brings a derivative legal action on  
31 behalf of a recipient, the Medicaid payor shall provide written  
32 notice no later than thirty days after filing the action to the  
33 recipient, the recipient's agent, and, if the Medicaid payor  
34 has actual knowledge that the recipient is represented by an  
35 attorney, to the attorney of the recipient, as applicable.

1 e. If the recipient or a recipient's agent brings an action  
2 against a third party, on or before the thirtieth day following  
3 the filing of the action, the recipient, the recipient's agent,  
4 or the attorney of the recipient or the recipient's agent,  
5 as applicable, shall provide written notice to the Medicaid  
6 payor of the action, including the name of the court in which  
7 the action is brought, the case number of the action, and a  
8 copy of the pleadings. The recipient, the recipient's agent,  
9 or the attorney of the recipient or the recipient's agent, as  
10 applicable, shall provide written notice of intent to dismiss  
11 the action at least twenty-one days before the voluntary  
12 dismissal of an action against a third party. Notice to the  
13 Medicaid payor shall be sent as specified by rule.

14 14. On or before the thirtieth day before the recipient  
15 finalizes a judgment, award, settlement, or any other recovery  
16 where the Medicaid payor has the right to recovery, the  
17 recipient, the recipient's agent, or the attorney of the  
18 recipient or recipient's agent, as applicable, shall give the  
19 Medicaid payor notice of the judgment, award, settlement,  
20 or recovery. The judgment, award, settlement, or recovery  
21 shall not be finalized unless such notice is provided and the  
22 Medicaid payor has had a reasonable opportunity to recover  
23 under the Medicaid payor's rights to subrogation, assignment,  
24 and lien. If the Medicaid payor is not given notice, the  
25 recipient, the recipient's agent, and the recipient's or  
26 recipient's agent's attorney are jointly and severally liable  
27 to reimburse the Medicaid payor for the recovery received to  
28 the extent of medical assistance paid by the Medicaid payor.  
29 The notice required under this subsection means written  
30 notice sent via certified mail to the address listed on the  
31 department's internet site for a Medicaid payor's third-party  
32 liability contact. The notice requirement is only satisfied  
33 for the specific Medicaid payor upon receipt by the specific  
34 Medicaid payor's third-party liability contact of such written  
35 notice sent via certified mail.

1 15. *a.* Except as otherwise provided in this section, the  
2 entire amount of any settlement of the recipient's action or  
3 claim involving third-party benefits, with or without suit, is  
4 subject to the Medicaid payor's claim for reimbursement of the  
5 amount of medical assistance provided and any lien pursuant to  
6 the claim.

7 *b.* Insurance and other third-party benefits shall not  
8 contain any term or provision which purports to limit or  
9 exclude payment or the provision of benefits for an individual  
10 if the individual is eligible for, or a recipient of, medical  
11 assistance, and any such term or provision shall be void as  
12 against public policy.

13 16. In an action in tort against a third party in which the  
14 recipient is a party and which results in a judgment, award, or  
15 settlement from a third party, the amount recovered shall be  
16 distributed as follows:

17 *a.* After deduction of reasonable attorney fees, reasonably  
18 necessary legal expenses, and filing fees, there is a  
19 rebuttable presumption that all Medicaid payors shall  
20 collectively receive two-thirds of the remaining amount  
21 recovered or the total amount of medical assistance provided by  
22 the Medicaid payors, whichever is less. A party may rebut this  
23 presumption in accordance with subsection 17.

24 *b.* The remaining recovered amount shall be paid to the  
25 recipient.

26 *c.* If the recovered amount available for the repayment of  
27 medical assistance is insufficient to satisfy the competing  
28 claims of the Medicaid payors, each Medicaid payor shall be  
29 entitled to the Medicaid payor's respective pro rata share of  
30 the recovered amount that is available.

31 17. *a.* A recipient or a recipient's agent who has notice  
32 or who has actual knowledge of the Medicaid payor's rights  
33 to third-party benefits under this section and who receives  
34 any third-party benefit or proceeds for a covered injury or  
35 illness shall on or before the sixtieth day after receipt of

1 the proceeds pay the Medicaid payor the full amount of the  
2 third-party benefits, but not more than the total medical  
3 assistance provided by the Medicaid payor, or shall place the  
4 full amount of the third-party benefits in an interest-bearing  
5 trust account for the benefit of the Medicaid payor pending a  
6 determination of the Medicaid payor's rights to the benefits  
7 under this subsection.

8 *b.* If federal law limits the Medicaid payor to reimbursement  
9 from the recovered damages for medical expenses, a recipient  
10 may contest the amount designated as recovered damages for  
11 medical expenses payable to the Medicaid payor pursuant to the  
12 formula specified in subsection 16. In order to successfully  
13 rebut the formula specified in subsection 16, the recipient  
14 shall prove, by clear and convincing evidence, that the portion  
15 of the total recovery which should be allocated as medical  
16 expenses, including future medical expenses, is less than the  
17 amount calculated by the Medicaid payor pursuant to the formula  
18 specified in subsection 16. Alternatively, to successfully  
19 rebut the formula specified in subsection 16, the recipient  
20 shall prove, by clear and convincing evidence, that Medicaid  
21 provided a lesser amount of medical assistance than that  
22 asserted by the Medicaid payor. A settlement agreement that  
23 designates the amount of recovered damages for medical expenses  
24 is not clear and convincing evidence and is not sufficient to  
25 establish the recipient's burden of proof, unless the Medicaid  
26 payor is a party to the settlement agreement.

27 *c.* If the recipient or the recipient's agent filed a legal  
28 action to recover against the third party, the court in which  
29 such action was filed shall resolve any dispute concerning  
30 the amount owed to the Medicaid payor, and shall retain  
31 jurisdiction of the case to resolve the amount of the lien  
32 after the dismissal of the action.

33 *d.* If the recipient or the recipient's agent did not file a  
34 legal action, to resolve any dispute concerning the amount owed  
35 to the Medicaid payor, the recipient or the recipient's agent

1 shall file a petition for declaratory judgment as permitted  
2 under rule of civil procedure 1.1101 on or before the one  
3 hundred twenty-first day after the date of payment of funds to  
4 the Medicaid payor or the date of placing the full amount of  
5 the third-party benefits in a trust account. Venue for all  
6 declaratory actions under this subsection shall lie in Polk  
7 county.

8 *e.* If a Medicaid payor and the recipient or the recipient's  
9 agent disagree as to whether a medical claim is related to a  
10 covered injury or illness, the Medicaid payor and the recipient  
11 or the recipient's agent shall attempt to work cooperatively  
12 to resolve the disagreement before seeking resolution by the  
13 court.

14 *f.* Each party shall pay the party's own attorney fees and  
15 costs for any legal action conducted under this subsection.

16 18. Notwithstanding any other provision of law to the  
17 contrary, when medical assistance is provided for a minor, any  
18 statute of limitation or repose applicable to an action or  
19 claim of a legally responsible relative for the minor's medical  
20 expenses is extended in favor of the legally responsible  
21 relative so that the legally responsible relative shall have  
22 one year from and after the attainment of the minor's majority  
23 within which to file a complaint, make a claim, or commence an  
24 action.

25 19. In recovering any payments in accordance with this  
26 section, the Medicaid payor may make appropriate settlements.

27 20. If a recipient or a recipient's agent submits via notice  
28 a request that the Medicaid payor provide an itemization of  
29 medical assistance paid for any covered injury or illness,  
30 the Medicaid payor shall provide the itemization on or before  
31 the sixty-fifth day following the day on which the Medicaid  
32 payor received the request. Failure to provide the itemization  
33 within the specified time shall not bar a Medicaid payor's  
34 recovery, unless the itemization response is delinquent for  
35 more than one hundred twenty days without justifiable cause. A

1 Medicaid payor shall not be under any obligation to provide a  
2 final itemization until a reasonable period of time after the  
3 processing of payment in relation to the recipient's receipt of  
4 final medical services. A Medicaid payor shall not be under  
5 any obligation to respond to more than one itemization request  
6 in any one-hundred-twenty-day period. The notice required  
7 under this subsection means written notice sent via certified  
8 mail to the address listed on the department's internet site  
9 for a Medicaid payor's third-party liability contact. The  
10 notice requirement is only satisfied for the specific Medicaid  
11 payor upon receipt by the specific Medicaid payor's third-party  
12 liability contact of such written notice sent via certified  
13 mail.

14 21. The department may adopt rules to administer this  
15 section and applicable federal requirements.

16 DIVISION II

17 MEDICAID MANAGED CARE ORGANIZATION TAXATION OF PREMIUMS

18 Sec. 3. NEW SECTION. 249A.13 Medicaid managed care  
19 organization premiums fund.

20 1. A Medicaid managed care organization premiums fund  
21 is created in the state treasury under the authority of the  
22 department of health and human services. Moneys collected by  
23 the director of the department of revenue as taxes on premiums  
24 pursuant to section 432.1A shall be deposited in the fund.

25 2. Moneys in the fund are appropriated to the department  
26 of health and human services for the purposes of the medical  
27 assistance program.

28 3. Notwithstanding section 8.33, moneys in the fund  
29 that remain unencumbered or unobligated at the close of a  
30 fiscal year shall not revert but shall remain available for  
31 expenditure for the purposes designated. Notwithstanding  
32 section 12C.7, subsection 2, interest or earnings on moneys in  
33 the fund shall be credited to the fund.

34 Sec. 4. NEW SECTION. 432.1A Health maintenance organization  
35 — medical assistance program — premium tax.

1 1. Pursuant to section 514B.31, subsection 3, a health  
2 maintenance organization contracting with the department of  
3 health and human services to administer the medical assistance  
4 program under chapter 249A, shall pay as taxes to the director  
5 of the department of revenue for deposit in the Medicaid  
6 managed care organization premiums fund created in section  
7 249A.13, an amount equal to two and one-half percent of  
8 the premiums received and taxable under subsection 514B.31,  
9 subsection 3.

10 2. Except as provided in subsection 3, the premium tax shall  
11 be paid on or before March 1 of the year following the calendar  
12 year for which the tax is due. The commissioner of insurance  
13 may suspend or revoke the license of a health maintenance  
14 organization subject to the premium tax in subsection 1 that  
15 fails to pay the premium tax on or before the due date.

16 3. *a.* Each health maintenance organization transacting  
17 business in this state that is subject to the tax in subsection  
18 1 shall remit on or before June 1, on a prepayment basis,  
19 an amount equal to one-half of the health maintenance  
20 organization's premium tax liability for the preceding calendar  
21 year.

22 *b.* In addition to the prepayment amount in paragraph  
23 "a", each health maintenance organization subject to the  
24 tax in subsection 1 shall remit on or before August 15, on  
25 a prepayment basis, an additional one-half of the health  
26 maintenance organization's premium tax liability for the  
27 preceding calendar year.

28 *c.* The sums prepaid by a health maintenance organization  
29 under paragraphs "a" and "b" shall be allowed as credits  
30 against the health maintenance organization's premium tax  
31 liability for the calendar year during which the payments are  
32 made. If a prepayment made under this subsection exceeds  
33 the health maintenance organization's annual premium tax  
34 liability, the excess shall be allowed as a credit against the  
35 health maintenance organization's subsequent prepayment or tax

1 liabilities under this section. The commissioner of insurance  
2 shall authorize the department of revenue to make a cash refund  
3 to a health maintenance organization, in lieu of a credit  
4 against subsequent prepayment or tax liabilities under this  
5 section, if the health maintenance organization demonstrates  
6 the inability to recoup the funds paid via a credit. The  
7 commissioner of insurance shall adopt rules establishing a  
8 health maintenance organization's eligibility for a cash  
9 refund, and the process for the department of revenue to make a  
10 cash refund to an eligible health maintenance organization from  
11 the Medicaid managed care organization premiums fund created in  
12 section 249A.13. The commissioner of insurance may suspend or  
13 revoke the license of a health maintenance organization that  
14 fails to make a prepayment on or before the due date under this  
15 subsection.

16 *d.* Sections 432.10 and 432.14 are applicable to premium  
17 taxes due under this section.

18 Sec. 5. Section 514B.31, Code 2023, is amended by striking  
19 the section and inserting in lieu thereof the following:

20 **514B.31 Taxation.**

21 1. For the first five years of the existence of a  
22 health maintenance organization and the health maintenance  
23 organization's successors and assigns, the following shall  
24 not be considered premiums received and taxable under section  
25 432.1:

26 *a.* Payments received by the health maintenance organization  
27 for health care services, insurance, indemnity, or other  
28 benefits to which an enrollee is entitled through a health  
29 maintenance organization authorized under this chapter.

30 *b.* Payments made by the health maintenance organization  
31 to providers for health care services, to insurers, or to  
32 corporations authorized under chapter 514 for insurance,  
33 indemnity, or other service benefits authorized under this  
34 chapter.

35 2. After the first five years of the existence of a

1 health maintenance organization and the health maintenance  
2 organization's successors and assigns, the following shall be  
3 considered premiums received and taxable under section 432.1:

4     *a.* Payments received by the health maintenance organization  
5 for health care services, insurance, indemnity, or other  
6 benefits to which an enrollee is entitled through a health  
7 maintenance organization authorized under this chapter.

8     *b.* Payments made by the health maintenance organization  
9 to providers for health care services, to insurers, or to  
10 corporations authorized under chapter 514 for insurance,  
11 indemnity, or other service benefits authorized under this  
12 chapter.

13     3. Notwithstanding subsections 1 and 2, beginning January  
14 1, 2024, and for each subsequent calendar year, the following  
15 shall be considered premiums received and taxable under section  
16 432.1A for a health maintenance organization contracting with  
17 the department of health and human services to administer the  
18 medical assistance program under chapter 249A:

19     *a.* Payments received by the health maintenance organization  
20 for health care services, insurance, indemnity, or other  
21 benefits to which an enrollee is entitled through a health  
22 maintenance organization authorized under this chapter.

23     *b.* Payments made by the health maintenance organization  
24 to providers for health care services, to insurers, or to  
25 corporations authorized under chapter 514 for insurance,  
26 indemnity, or other service benefits authorized under this  
27 chapter.

28     4. Payments made to a health maintenance organization  
29 by the United States secretary of health and human services  
30 under a contract issued under section 1833 or 1876 of the  
31 federal Social Security Act, or under section 4015 of the  
32 federal Omnibus Budget Reconciliation Act of 1987, shall not  
33 be considered premiums received and shall not be taxable under  
34 section 432.1 or 432.1A. Payments made to a health maintenance  
35 organization contracting with the department of health and

1 human services to administer the medical assistance program  
2 under chapter 249A shall not be taxable under section 432.1.

3 EXPLANATION

4 The inclusion of this explanation does not constitute agreement with  
5 the explanation's substance by the members of the general assembly.

6 This bill relates to the Medicaid program including recovery  
7 by the department of health and human services (HHS or the  
8 department) from third parties and taxation of Medicaid managed  
9 care organization premiums.

10 DIVISION I — MEDICAID PROGRAM THIRD-PARTY RECOVERY. The  
11 bill strikes and replaces current provisions in Code section  
12 249A.37 (health care information sharing) and Code section  
13 249A.54 (assignment — lien).

14 Under the bill, new Code section 249A.37 (duties of third  
15 parties) relates to the duties of third parties, defined  
16 under the bill as "an individual, entity, or program,  
17 excluding Medicaid, that is or may be liable to pay all or  
18 a part of the expenditures for medical assistance provided  
19 by a Medicaid payor to the recipient". The listing of  
20 "third parties" includes but is not limited to a third-party  
21 administrator, a pharmacy benefits manager, a health insurer, a  
22 self-insured plan, a group health plan, a service benefit plan,  
23 a managed care organization, liability insurance including  
24 self-insurance, no-fault insurance, workers' compensation laws  
25 or plans, and other parties that by law, contract, or agreement  
26 are legally responsible for payment of a claim for a medical  
27 service. The bill also defines terms including "Medicaid  
28 payor", "recipient", "third party", and "third-party benefits".

29 The bill provides that the third-party obligations specified  
30 under the bill are a condition of doing business in the state,  
31 and a third party that fails to comply with these obligations  
32 shall not be eligible to do business in the state.

33 The bill requires that a third party that is a carrier shall  
34 enter into a health insurance data match program with HHS  
35 for the sole purpose of comparing the names of the carrier's

1 insureds with the names of recipients as required by Code  
2 section 505.25 (information provided to medical assistance  
3 program, Hawki program, and child support services).

4 The bill specifies the duties of a third party under the  
5 Medicaid program including cooperating with the Medicaid payor  
6 in identifying recipients for whom third-party benefits are  
7 available; accepting the Medicaid payor's rights of recovery  
8 and assignment to the Medicaid payor for payments which the  
9 Medicaid payor has made; accepting authorization provided by  
10 the Medicaid payor that the health care item or service is  
11 covered as if such authorization were the prior authorization  
12 made by the third party for such health care item or service;  
13 responding to inquiries from Medicaid payors regarding claims  
14 for payment; and not denying claims submitted by a Medicaid  
15 payor solely on the basis of the date of submission of the  
16 claim, the type or format of the claim form, a failure to  
17 present proper documentation, or in the case of specified  
18 third-party payors solely on the basis of a failure to obtain  
19 prior authorization if certain conditions are met.

20 The department may adopt administrative rules to administer  
21 this Code section of the bill. Rules governing the exchange  
22 of information under the bill shall be consistent with all  
23 laws, regulations, and rules relating to the confidentiality or  
24 privacy of personal information or medical records, including  
25 but not limited to the federal Health Insurance Portability  
26 and Accountability Act (HIPAA) and regulations promulgated in  
27 accordance with HIPAA.

28 Under new Code section 249A.54 (responsibility for payment  
29 on behalf of Medicaid-eligible persons — liability of other  
30 parties) the bill includes specific provisions relating to the  
31 responsibility for payment on behalf of Medicaid recipients,  
32 which include both persons who have applied for and persons  
33 who have received medical assistance, when other parties are  
34 liable.

35 The bill provides that it is the intent of the general

1 assembly that Medicaid payors be the payor of last resort for  
2 medical services furnished to recipients. All other sources of  
3 payment for medical services are primary relative to medical  
4 assistance provided by the Medicaid payor. If benefits of a  
5 third party are discovered or become available after medical  
6 assistance has been provided by the Medicaid payor, it is  
7 the intent of the general assembly that the Medicaid payor  
8 be repaid in full and prior to any other person, program, or  
9 entity. The Medicaid payor shall be repaid in full from and to  
10 the extent of any third-party benefits, regardless of whether a  
11 recipient is made whole or other creditors paid.

12 The bill provides definitions for "collateral", "covered  
13 injury or illness", "Medicaid payor", "medical service",  
14 "payment", "proceeds", "recipient" which includes both an  
15 applicant for and recipient of medical assistance, "recipient's  
16 agent", "third party", and "third-party benefits".

17 The bill provides that third-party benefits for medical  
18 services shall be primary relative to medical assistance  
19 provided by the Medicaid payor. A Medicaid payor has all of  
20 the rights, privileges, and responsibilities identified under  
21 the bill, but if HHS determines that a Medicaid payor has not  
22 taken reasonable steps within a reasonable time to recover  
23 third-party benefits, HHS may exercise all of the rights of the  
24 Medicaid payor to the exclusion of the Medicaid payor following  
25 provision of notice to third parties and the Medicaid payor.

26 A Medicaid payor may assign the Medicaid payor's rights  
27 under the bill, including to another Medicaid payor, a  
28 provider, or a contractor. After the Medicaid payor has  
29 provided medical assistance, the Medicaid payor shall seek  
30 reimbursement for third-party benefits to the extent of the  
31 Medicaid payor's legal liability and for the full amount of  
32 the third-party benefits, but not in excess of the amount of  
33 medical assistance provided by the Medicaid payor.

34 Within 30 days following discovery by a recipient of  
35 potential third-party benefits, a recipient or the recipient's

1 agent, as applicable, shall inform the Medicaid payor of any  
2 rights the recipient has to third-party benefits and provide  
3 identifying information for any person that is or may be liable  
4 to provide third-party benefits.

5 The bill specifies the rights of a Medicaid payor when  
6 the Medicaid payor provides or becomes liable for medical  
7 assistance, including that the Medicaid payor is automatically  
8 subrogated to any rights that a recipient or a recipient's  
9 agent or legally liable relative has to any third-party  
10 benefit for the full amount of medical assistance provided by  
11 the Medicaid payor; that the Medicaid payor is automatically  
12 assigned any right, title, and interest a recipient or  
13 a recipient's agent or legally liable relative has to a  
14 third-party benefit by virtue of applying for, accepting, or  
15 accepting the benefit of medical assistance, excluding any  
16 Medicare benefit to the extent required to be excluded by  
17 federal law; and that the Medicaid payor is entitled to and  
18 has an automatic lien upon the collateral for the full amount  
19 of medical assistance provided by the Medicaid payor to or on  
20 behalf of the recipient for medical services furnished as a  
21 result of any covered injury or illness for which a third party  
22 is or may be liable.

23 Unless otherwise provided in the bill, the Medicaid payor  
24 shall recover the full amount of all medical assistance  
25 provided by the Medicaid payor on behalf of the recipient  
26 to the full extent of third-party benefits. A recipient  
27 and the recipient's agent shall cooperate in the Medicaid  
28 payor's recovery of the recipient's third-party benefits and  
29 in establishing paternity and support of a recipient child  
30 born out of wedlock. The Medicaid payor has the discretion  
31 to waive, in writing, the requirement of cooperation for good  
32 cause shown and as required by federal law. The department may  
33 deny or terminate eligibility for any recipient who refuses to  
34 cooperate, unless HHS has waived cooperation.

35 Within 30 days of initiating formal or informal recovery,

1 other than by filing a lawsuit, a recipient's attorney shall  
2 provide written notice of the activity or action to the  
3 Medicaid payor.

4 A recipient is deemed to have authorized the Medicaid payor  
5 to obtain and release medical information and other records  
6 with respect to the recipient's medical services for the sole  
7 purpose of obtaining reimbursement for medical assistance  
8 provided by the Medicaid payor.

9 To enforce the Medicaid payor's rights, the Medicaid  
10 payor may institute, intervene in, or join in any legal or  
11 administrative proceeding in the Medicaid payor's own name, and  
12 in a number or a combination of capacities listed in the bill.  
13 An action by the Medicaid payor to recover damages in an action  
14 in tort, which is derivative of the rights of the recipient,  
15 shall not constitute a waiver of sovereign immunity.

16 A Medicaid payor, other than HHS, shall obtain written  
17 consent from HHS before the Medicaid payor files a derivative  
18 legal action on behalf of a recipient, and when a Medicaid  
19 payor brings such a derivative action, the Medicaid payor shall  
20 provide written notice no later than 30 days after filing the  
21 action to the recipient, the recipient's agent, and, if the  
22 Medicaid payor has actual knowledge that the recipient is  
23 represented by an attorney, to the attorney of the recipient,  
24 as applicable.

25 If an action is filed by a recipient or a recipient's agent  
26 against a third party, the recipient, the recipient's agent,  
27 or the attorney of the recipient or the recipient's agent,  
28 as applicable, shall provide written notice to the Medicaid  
29 payor of the action, including the name of the court in which  
30 the action is brought, the case number of the action, and a  
31 copy of the pleadings. The recipient, the recipient's agent,  
32 or the attorney of the recipient or the recipient's agent,  
33 as applicable, shall also provide written notice of intent  
34 to dismiss the action prior to the voluntary dismissal of an  
35 action against a third party.

1 Before a recipient finalizes a judgment, award, settlement,  
2 or any other recovery where the Medicaid payor has the right  
3 to recovery, the recipient, the recipient's agent, or the  
4 attorney of the recipient or recipient's agent, as applicable,  
5 shall give the Medicaid payor notice, as specified, of the  
6 judgment, award, settlement, or recovery. The judgment,  
7 award, settlement, or recovery shall not be finalized  
8 unless the notice is provided and the Medicaid payor has  
9 a reasonable opportunity to recover under its rights to  
10 subrogation, assignment, and lien. If notice is not provided,  
11 the recipient, the recipient's agent, and the recipient's or  
12 recipient's agent's attorney are jointly and severally liable  
13 to reimburse the Medicaid payor for the recovery received to  
14 the extent of medical assistance paid by the Medicaid payor.

15 Unless otherwise provided, the entire amount of any  
16 settlement of the recipient's action or claim involving  
17 third-party benefits is subject to the Medicaid payor's claim  
18 for reimbursement of the amount of medical assistance provided  
19 and any lien pursuant to the claim.

20 The bill prohibits insurance and other third-party benefits  
21 from containing any term or provision which purports to  
22 limit or exclude payment or the provision of benefits for an  
23 individual if the individual is eligible for, or a recipient  
24 of, medical assistance, and any such term or provision shall be  
25 void as against public policy.

26 In an action in tort against a third party in which the  
27 recipient is a party, of the amount recovered in any resulting  
28 judgment, award, or settlement from a third party, after  
29 deduction of reasonable attorney fees, reasonably necessary  
30 legal expenses, and filing fees, there is a rebuttable  
31 presumption that all Medicaid payors shall collectively receive  
32 two-thirds of the remaining amount recovered or the total  
33 amount of medical assistance provided by the Medicaid payors,  
34 whichever is less; and the remaining amount recovered shall be  
35 paid to the recipient. In calculating the Medicaid payor's

1 recovered amount of medical assistance, the fee for services of  
2 an attorney retained by the recipient or the recipient's legal  
3 representative shall not exceed one-third of the judgment,  
4 award, or settlement amount. If the recovered amount is  
5 insufficient to satisfy the competing claims of the Medicaid  
6 payors, each Medicaid payor shall be entitled to the Medicaid  
7 payor's respective pro rata share of the recovered amount that  
8 is available.

9 A recipient or a recipient's agent who has notice or  
10 who has actual knowledge of the Medicaid payor's rights to  
11 third-party benefits who receives any third-party benefit or  
12 proceeds for a covered injury or illness, shall after receipt  
13 of the proceeds pay the Medicaid payor the full amount of the  
14 third-party benefits, but not more than the total medical  
15 assistance provided by the Medicaid payor, or shall place the  
16 full amount of the third-party benefits in an interest-bearing  
17 trust account for the benefit of the Medicaid payor pending a  
18 determination of the Medicaid payor's rights to the benefits.

19 If federal law limits the Medicaid payor to reimbursement  
20 from the recovered damages for medical expenses, a recipient  
21 may contest the amount designated as recovered damages for  
22 medical expenses payable to the Medicaid payor as specified  
23 in the formula under the bill. To successfully rebut the  
24 formula, the recipient shall prove, by clear and convincing  
25 evidence, that the portion of the total recovery which should  
26 be allocated as medical expenses, including future medical  
27 expenses, is less than the amount calculated by the Medicaid  
28 payor pursuant to the formula. Alternatively, to successfully  
29 rebut the formula, the recipient shall prove, by clear and  
30 convincing evidence, that Medicaid provided a lesser amount of  
31 medical assistance than that asserted by the Medicaid payor. A  
32 settlement agreement that designates the amount of recovered  
33 damages for medical expenses is not clear and convincing  
34 evidence and is not sufficient to establish the recipient's  
35 burden of proof, unless the Medicaid payor is a party to the

1 settlement agreement.

2 If the recipient or the recipient's agent filed a legal  
3 action to recover against the third party, the court in which  
4 such action was filed shall resolve any dispute concerning  
5 the amount owed to the Medicaid payor, and shall retain  
6 jurisdiction of the case to resolve the amount of the lien  
7 after the dismissal of the action. If the recipient or the  
8 recipient's agent did not file a legal action to resolve any  
9 dispute concerning the amount owed to the Medicaid payor, the  
10 recipient or the recipient's agent shall file a petition for  
11 declaratory judgment. Venue for all such declaratory actions  
12 shall lie in Polk county. Each party shall pay the party's own  
13 attorney fees and costs for any legal action conducted under  
14 this provision of the bill.

15 If a Medicaid payor and the recipient or the recipient's  
16 agent disagree as to whether a medical claim is related to a  
17 covered injury or illness, the Medicaid payor and the recipient  
18 or the recipient's agent shall attempt to work cooperatively  
19 to resolve the disagreement before seeking resolution by the  
20 court.

21 With regard to medical assistance provided to a minor, and  
22 notwithstanding any other provision of law to the contrary, any  
23 statute of limitations or repose applicable to an action or  
24 claim of a legally responsible relative for the minor's medical  
25 expenses is extended in favor of the legally responsible  
26 relative so that the legally responsible relative shall have  
27 one year from and after the attainment of the minor's majority  
28 within which to file a complaint, make a claim, or commence an  
29 action.

30 In recovering any payments under the bill, the Medicaid  
31 payor may make appropriate settlements.

32 The bill provides the process and limitations for a request  
33 by a recipient or a recipient's agent that a Medicaid payor  
34 provide an itemization of medical assistance paid for any  
35 covered injury or illness via notice as specified under the

1 bill.

2 The department may adopt administrative rules to administer  
3 this portion of the bill and applicable federal requirements.

4 DIVISION II — MEDICAID MANAGED CARE ORGANIZATION

5 TAXATION OF PREMIUMS. The bill relates to taxation of health  
6 maintenance organizations.

7 Under current Code section 514B.31 (taxation), for the  
8 first five years of the existence of a health maintenance  
9 organization (HMO) or its successor, payments received by the  
10 HMO for health care services, insurance, indemnity, or other  
11 benefits to which an enrollee is entitled, and payments made by  
12 the HMO to a provider for health care services, to insurers, or  
13 to corporations authorized under Code chapter 514 (nonprofit  
14 health services corporations) for insurance, indemnity, or  
15 other service benefits, are not considered premiums received  
16 and not taxable under Code section 432.1 (tax on gross premiums  
17 — exclusions). After five years, payments received by the  
18 HMO or its successor for health care services, insurance,  
19 indemnity, or other benefits to which an enrollee is entitled,  
20 and payments made by the HMO to a provider for health care  
21 services, to insurers, or to corporations authorized under  
22 Code chapter 514 (nonprofit health services corporations)  
23 for insurance, indemnity, or other service benefits, are  
24 considered premiums received and taxable under Code section  
25 432.1. Current Code section 514B.31 also provides that certain  
26 payments made by the United States secretary of health and  
27 human services are not considered premiums and therefore not  
28 taxable under Code section 432.1.

29 The bill amends Code section 514B.31 to exempt from  
30 consideration as premiums and therefore not taxable under  
31 either Code section 432.1 (tax on gross premiums — exclusions)  
32 or new Code section 432.1A (health maintenance organization —  
33 medical assistance program — premium tax) payments to health  
34 maintenance organizations from the United States secretary of  
35 health and human services under contracts issued under section

1 1833 or 1876 of the federal Social Security Act or section  
2 4015 of the federal Omnibus Budget Reconciliation Act of 1987.  
3 However, the bill provides that payments made to a health  
4 maintenance organization contracting with HHS to administer the  
5 Medicaid program shall not be taxable only under Code section  
6 432.1. The bill also amends Code section 514B.31 to provide  
7 that notwithstanding the provisions applicable to HMOs under  
8 Code section 514B.31 relating to a premium tax, beginning  
9 January 1, 2024, and for each subsequent calendar year, for an  
10 HMO contracting with HHS to administer the medical assistance  
11 program under Code chapter 249A, payments received by the  
12 HMO for health care services, insurance, indemnity, or other  
13 benefits to which an enrollee is entitled, and payments made by  
14 the HMO to a provider for health care services, to insurers,  
15 or to corporations authorized under Code chapter 514 for  
16 insurance, indemnity, or other service benefits, are considered  
17 premiums received and taxable under new Code section 432.1A.

18 The bill establishes under new Code section 432.1A the  
19 parameters of the new tax on HMOs contracting with HHS to  
20 administer the medical assistance program under Code chapter  
21 249A. Such HMOs shall pay as taxes to the director of the  
22 department of revenue for deposit in the Medicaid managed care  
23 organization premiums fund an amount equal to 2.5 percent of  
24 the premiums received and taxable. The premium tax shall be  
25 paid on or before March 1 of the year following the calendar  
26 year for which the tax is due. The commissioner of insurance  
27 may suspend or revoke the license of an HMO subject to the  
28 premium tax that fails to pay the premium tax on or before the  
29 due date. Code sections 432.10 (sufficiency of remitted tax  
30 — notice) and 432.14 (statute of limitations) apply to the  
31 premium tax due.

32 An HMO subject to the new tax shall remit on or before June  
33 1, on a prepayment basis, an amount equal to one-half of the  
34 HMO's premium tax liability for the preceding calendar year;  
35 and shall remit on or before August 15, on a prepayment basis,

1 an additional one-half of the HMO's premium tax liability  
2 for the preceding calendar year. If a prepayment exceeds  
3 the HMO's annual premium tax liability, the excess shall be  
4 allowed as a credit against the HMO's subsequent prepayment  
5 or tax liabilities. The HMO may receive a credit or a cash  
6 refund in lieu of a credit against subsequent prepayment or  
7 tax liabilities. The commissioner of insurance may suspend or  
8 revoke the license of an HMO that fails to make a prepayment on  
9 or before the due date.

10 The bill creates in new Code section 249A.13 a Medicaid  
11 managed care organization premiums fund in the state treasury  
12 under the authority of HHS. Moneys collected from the new  
13 tax on premiums shall be deposited in the fund. Moneys in  
14 the fund are appropriated to HHS for the purposes of the  
15 medical assistance program. Moneys in the fund that remain  
16 unencumbered or unobligated at the close of a fiscal year shall  
17 not revert but shall remain available for expenditure for the  
18 purposes designated. Interest or earnings on moneys in the  
19 fund shall be credited to the fund.